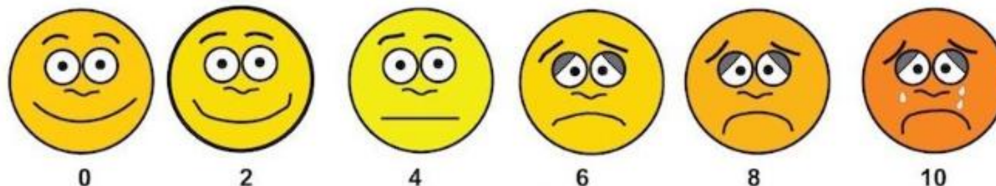
NCH Physician Group

Department of Orthopaedic Surgery & Sports Medicine
Gregory Rubin, DO
New Patient Intake Form

Name:	Date of Birth: Age:	Height: Weight:
Referred today by:	Primary Care Physician:	
Preferred Pharmacy:		
Reason you are being seen today:		
Which side of your body is injured: ☐Right ☐Left ☐Bilateral		
When did it start?		
Is it: ☐Sharp ☐Burning ☐Dull ☐Aching ☐Throbbing		
Does it radiate? ☐No ☐Yes radiates to ________________________________		
When does it occur? ☐Morning ☐Night ☐Constant ☐After exercise ☐During exercise ☐Intermittent		
Has it: ☐Improved ☐Stayed the same ☐Worsened		
What makes it better:		
What makes it worse:		
Do you have any of the following: ☐Swelling ☐Numbness ☐Bruising ☐Tingling		

Please circle the number that best describes your pain:



Review of systems

General: ☐Lack of energy ☐Weight gain ☐Fever ☐Night sweats
Ears, nose, mouth, and throat: ☐Hearing loss ☐Seasonal allergies ☐Vision loss ☐Ear pain
Cardiac: ☐Chest pain ☐Irregular heartbeat ☐Leg swelling
Respiratory: ☐Shortness of breath ☐Cough ☐Wheezing ☐Sputum production
Gastrointestinal:☐Diarrhea ☐Constipation ☐Abdominal pain ☐Vomiting ☐Blood in stool ☐Bowel incontinence
Hematology: ☐Easy bleeding ☐Easy bruising ☐Anemia ☐Hx of cancer
Endocrine: ☐Intolerance to heat or cold
Genitourinary: ☐Urinary incontinence ☐Urinary frequency
Neurologic: ☐Headaches ☐Problems walking ☐Tremor
Psychiatric: ☐Anxiety ☐Depression ☐Irritability

Medications and Supplements ☐None

1.	9.
2.	10.
3.	11.
4.	12.
5.	13.

6.	14.
7.	15.
8.	16.

Medication Allergies: ☐No Known Medication Allergies

1.	3.	5.	7.
2.	4.	6.	8.

Past Medical History: ☐None

☐Acid Reflux	☐Depression	☐Hernia	☐Peripheral Vascular Disease
☐AIDS/HIV	☐Diabetes Type:_________	☐High Blood Pressure	☐Seizure
☐Anemia	☐Drug Addiction	☐High Cholesterol	☐Skin Disorder
☐Anxiety Disorder	☐Emphysema	☐Kidney Disease	☐Stroke
☐Arthritis	☐Fibromyalgia	☐Migraines	☐Thyroid issues
☐Asthma	☐Colon cancer	☐Mitral Valve Prolapse	☐Tuberculosis
☐Blood clots	☐Glaucoma	☐Neuropathy	☐Urinary Incontinence
☐Cancer Type:______________________	☐Coronary artery disease	☐Osteopenia	☐Other:
☐Cataracts	☐Heart Failure	☐Osteoporosis	
☐COPD	☐Hepatitis	☐Pacemaker	

Surgical History: ☐None

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Family History: ☐None

Other:

Social History:

Alcohol Use:	☐None	☐Current	☐Beer ☐Wine ☐Liquor	Frequency:
Tobacco Use:	☐None	☐Former Date quit:	☐Current Packs per day:	Ready to quit: ☐Yes ☐No

Employment:	☐Retired	☐Student	☐Full-time	☐Part-time	☐Unemployed
Company:			Title:		
Preferred Spoken Language:			Preferred Language for Learning:		

Advanced Directives: ☐None ☐Living Will ☐Power of Attorney

Sign below to ensure all information above is correct:

_______________________________________ _____________________________

Patient or Legal Guardian's Signature Date/Time